STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445239	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF MORGAN COUNTY	419 SOUTH KINGSTON STREET WARTBURG, TN 37887

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A life safety survey was conducted by the state of Tennessee Department of Health, Division of health licensure and regulation office of health care facilities on 8/28/17. During this life safety survey, Life Care Center of Morgan County was not found to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR Subpart 483.70(a), Life safety from fire, and the related National Fire Protection Association (NFPA) standard 101 - 2012 edition. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 291 SS=F	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9, 18.2.9.1, 19.2.9.1 This STANDARD is not met as evidenced by: Based on observation, record review and interview the facility failed to maintain the emergency lighting. This deficiency was 3 of 6 smoke compartments. NFPA 101, 19.7.6 & 7.9.3.1 The finding includes: Observation, record review and interview with the maintenance director on 8/28/17 at 8:43 AM revealed the 90 minute annual testing on emergency lighting was not being conducted. The maintenance director was present when the deficiency was identified and was acknowledged	K 291	K 291 1. <u>What corrective actions will be accomplished for those residents found to have been effected by the deficient practice?</u> The facility completed and documented the 90 min. test that is required. The wires were removed and tested on battery power for 90 mins by the maintenance director on September 1st. This includes all exit signs throughout the facility.	09/01/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: B. Lett A
TITLE: Executive Director
(X6) DATE: 9/14/17

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	INITIAL COMMENTS	K 000		

A life safety survey was conducted by the state of Tennessee Department of Health, Division of health licensure and regulation office of health care facilities on 8/28/17. During this life safety survey, Life Care Center of Morgan County was not found to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR Subpart 483.70(a), Life safety from fire, and the related National Fire Protection Association (NFPA) standard 101 - 2012 edition.

The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:

K 291 SS=F NFPA 101 Emergency Lighting

Emergency Lighting
Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1
This STANDARD is not met as evidenced by:
Based on observation, record review and interview the facility failed to maintain the emergency lighting. This deficiency was 3 of 6 smoke compartments.

NFPA 101, 19.7.6 & 7.9.3.1

The finding includes:

Observation, record review and interview with the maintenance director on 8/28/17 at 8:43 AM revealed the 90 minute annual testing on emergency lighting was not being conducted.

The maintenance director was present when the deficiency was identified and was acknowledged

K 291

2. How will you identify other residents having the potential to be effected by the same deficient practice and what corrective action will be taken?

This exercise will be done annually throughout the building and documented. The documentation will be in the maintenance director's office.

3. What measures will be put in place or what systematic changes you will make to ensure that the deficient practice does not recur?

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: B. Letts

TITLE: Executive Director

(X6) DATE: 9/14/17

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 291 SS=F	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This STANDARD is not met as evidenced by: Based on observation, record review and interview the facility failed to maintain the emergency lighting. This deficiency was 3 of 6 smoke compartments. NFPA 101, 19.7.6 & 7.9.3.1 The finding includes: Observation, record review and interview with the maintenance director on 8/28/17 at 8:43 AM revealed the 90 minute annual testing on emergency lighting was not being conducted. The maintenance director was present when the deficiency was identified and was acknowledged	K 291	Monthly checks of all emergency lighting will be done by the Maintenance Director and checked by the Executive Director. This will be accomplished during rounds that are made and documented. 4. How will the corrective action be monitored to ensure the deficient practice will not recur?	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
B. Scott Hunt	Executive Director	9/14/17

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K 000	INITIAL COMMENTS A life safety survey was conducted by the state of Tennessee Department of Health, Division of health licensure and regulation office of health care facilities on 8/28/17. During this life safety survey, Life Care Center of Morgan County was not found to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR Subpart 483.70(a), Life safety from fire, and the related National Fire Protection Association (NFPA) standard 101 - 2012 edition. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 291 SS=F	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9.18.2.9.1, 19.2.9.1 This STANDARD is not met as evidenced by: Based on observation, record review and interview the facility failed to maintain the emergency lighting. This deficiency was 3 of 6 smoke compartments. NFPA 101, 19.7.6 & 7.9.3.1 The finding includes: Observation, record review and interview with the maintenance director on 8/28/17 at 8:43 AM revealed the 90 minute annual testing on emergency lighting was not being conducted. The maintenance director was present when the deficiency was identified and was acknowledged	K 291	The Maintenance Director will report findings of the monthly audit to the PI committee. The committee consists of the Executive Director, DON, ADON, Medical Director, Director of Rehabilitation, Director of Health Management, Dietitian, Director of Maintenance, Director of Environmental Services, Director of Social Services, Business Office Manager, Activities Director, and Staff Development Director for the next 3 months.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Executive Director	9/14/17

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 291	Continued From page 1 by the director of nursing during the exit conference on 8/28/17.	K 291		
K 324 SS=D	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the commercial cooking equipment. This deficiency affected 1 of 6 smoke compartments. NFPA 101, 19.3.2.5.3 NFPA 96, 10.2.7.3	K 324	K 324 1. What corrective actions will be accomplished for those residents found to have been effected by the deficient practice? The facility has corrected the hood suppression nozzles by stabilized the nozzles to point to the cooking surface. This was completed by the Maintenance Director/ Maintenance Assistant on August 28th. All grease build up on the stove top has been removed and cleaned by the Dietary Mgr. on September 1. 2. How will you identify other residents having the potential to be effected by the same deficient practice and what corrective action will be taken?	09/01/17

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K 291	Continued From page 1 by the director of nursing during the exit conference on 8/28/17.	K 291		
K 324 SS=D	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the commercial cooking equipment. This deficiency affected 1 of 6 smoke compartments. NFPA 101, 19.3.2.5.3 NFPA 96, 10.2.7.3	K 324	The maintenance director will examine the hood and stove top on monthly rounds to assure compliance. Any time work is done in the kitchen, a recheck will be completed and documented. 3. What measures will be put in place or what systematic changes you will make to ensure that the deficient practice does not recur? The Maintenance department makes rounds monthly to assure the kitchen is meeting the standard. Any work will be documented. 4. How will the corrective action be monitored to ensure the deficient practice will not recur?	

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K 324	Continued From page 2 The findings include: Observation and interview with the maintenance director on 8/28/17 at 9:30 AM revealed; 1. The ANSUL hood suppression nozzles were not aimed at the cooking surfaces, they were rotated to the rear and the top shelf was obstructing them. 2. There was excessive grease build-up on the stove top and behind the fryer. The maintenance director was present when the deficiencies were identified, and was acknowledged by the director of nursing during the exit conference on 8/28/17.	K 324	The Maintenance Director will report findings of the monthly audit to the PI committee. The committee consists of the Executive Director, DON, ADON, Medical Director, Director of Rehabilitation, Director of Health Management, Dietitian, Director of Maintenance, Director of Environmental Services, Director of Social Services, Business Office Manager, Activities Director, and Staff Development Director for the next 3 months.	
K 521 SS=F	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This STANDARD is not met as evidenced by: Based on observation, record review and interview the facility failed to maintain fire dampers. This deficiency affected 6 of 6 smoke compartments. NFPA 101, 19.7.6 NFPA 80, 19.4.1.1	K 521	1. <u>What corrective actions will be accomplished for those residents found to have been effected by the deficient practice?</u> The facility has corrected and documented all damper inspections throughout the	09/08/17

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K 521	Continued From page 3 The finding includes: Observation, record review and interview with the maintenance director on 8/26/17 at 8:28 AM revealed the damper inspections were started but not complete. The maintenance director was present when the deficiency was identified and was acknowledged by the director of nursing during the exit conference on 8/28/17.	K 521	building by the Maintenance Director/ Maintenance Assistant on September 8th. These will be checked in accordance with the manufacturer's specifications. 2. How will you identify other residents having the potential to be effected by the same deficient practice and what corrective action will be taken? 100% audit by the Maintenance Director has been done and all meet the manufacturer's specification. Monthly checks will be completed and documented. 3. What measures will be put in place or what systematic changes you will make to ensure that the deficient practice does not recur? Monthly checks by the maintenance department will be done. All dampers will be checked and documented.	

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K 521	Continued From page 3 The finding includes: Observation, record review and interview with the maintenance director on 8/26/17 at 8:28 AM revealed the damper inspections were started but not complete. The maintenance director was present when the deficiency was identified and was acknowledged by the director of nursing during the exit conference on 8/28/17.	K 521	4. How will the corrective action be monitored to ensure the deficient practice will not recur? The Maintenance Director will report findings of the monthly audit to the PI committee. The committee consists of the Executive Director, DON, ADON, Medical Director, Director of Rehabilitation, Director of Health Management, Dietitian, Director of Maintenance, Director of Environmental Services, Director of Social Services, Business Office Manager, Activities Director, and Staff Development Director for the next 3 months.	